Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

www.dmas.virginia.gov

MEDICAID MEMO

TO: All Providers and Managed Care Organizations (MCOs) participating in the Virginia Medical Assistance Program

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services (DMAS)

MEMO Special

DATE 12/2/2005

SUBJECT: Implementation of ClaimCheck for all Physician and Laboratory Services – Effective January 9, 2006

This purpose of this memorandum is to inform providers that DMAS will be re-implementing McKesson's claims editing software, ClaimCheck, on January 9, 2006, for all Physician and Laboratory Services. This process will involve all Physician and Laboratory Services claims received on or after January 9, 2006.

DMAS has been working with an established ClaimCheck provider workgroup for the last year. This workgroup is comprised of various individual and group providers, physician specialists, and professional organizations. The workgroup assists DMAS with insuring that ClaimCheck edits adhere to state and federal standard billing guidelines and provide information on normal physician office standards. This workgroup will remain active and continue to review any updates to the ClaimCheck process as needed.

ClaimCheck will be implemented into the daily claims adjudication cycle on a concurrent basis. This implementation will result in the current claim being processed to edit against history claims. Therefore, any adjustment or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported via the weekly remittance.

DMAS has outlined the logic and rules of the editing criteria in the enclosed attachment. All ClaimCheck edits are invoked based on the following global claim factors: same recipient, same provider, same date of service, or date of service is within the established pre- or post-operative time frame.

DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck process. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. The Division of Program Integrity will monitor and audit the use of these

modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

The modifiers that currently bypass the ClaimCheck edits are:

- Modifier 24 – Unrelated E & M Service by the same Physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M Service on the same day by the same Physician on the same day of the procedure or other services.
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Department of Medical Assistance Services
Payment Processing Unit – ClaimCheck
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS has determined that there are specific procedure codes that should be excluded from the ClaimCheck process due to federal or state requirements that are unique to DMAS. The second attachment contains the procedure codes identified to be excluded.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the Provider Column to find Medicaid and SLH (State and Local Hospitalization Program) Provider Manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include upcoming changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at www.dmas.virginia.gov/pr-provider_newletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

Attached Number of Pages: (7)

ClaimCheck Edit Examples

Re-bundling Edit: There are two or more procedure codes reported when a single, more comprehensive procedure code exists. ClaimCheck will "re-bundle" the unbundled procedure codes into the one comprehensive procedure code. The unbundled procedures will be voided or denied, and the comprehensive code will be added and paid.

Procedure Code Billed	Description	Procedure Code Paid	Procedure Code Denied
Example 1			
99391	Comprehensive Preventive Med	99391	
99341	History and Exam Normal Newborn		99341
Example 2			
82310	Calcium		82310
82374	Carbon Dioxide		82374
82435	Chloride		82435
82565	Creatinine		82565
82947	Glucose		82947
84132	Potassium		84132
84295	Sodium		84295
84520	Urea Nitrogen		84520
80048	Basic Metabolic Panel	80048	

Incidental Edit: A procedure code is performed and billed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure. The "incidental" procedure code will be denied reimbursement.

Procedure Code Billed	Description	Procedure Code Paid	Procedure Code Denied
Example 1			
57410	Pelvic Exam Under Anesthesia		57410
58120	Dilation and Curettage	58120	
Example 2			
92012	Opthalmological Services; Medical E&M	92012	
92015	Determination of Refractive State	92015	
92225	Ophthalmoscopy, Extended		92225

Mutually Exclusive Edit: When a combination of procedures that differ in technique or approach lead to the same outcome. In some instances, the procedures can be anatomically impossible, represent overlapping services, or can accomplish the same results. The procedure code with the highest relative value unit (RVU) will be reimbursed.

Procedure Code Billed	Description	Procedure Code Paid	Procedure Code Denied
Example 1			
85007	Blood Count, Smear, Micro exam with manual Diff. WBC & Platelet Count		85007
85027	Complete blood count, automated	85027	
Example 2			
31231	Nasal Endoscopy, diagnostic, unilateral or bilateral		31231
31254	Nasal/Sinus Endoscopy, surgical with ethmoidectomy, partial		31254
31255	Nasal/Sinus Endoscopy, surgical with ethmoidectomy, total	31255	

Pre- and Post-Operative Visit Edit: This edit utilizes the Center for Medicare and Medicaid Services' (CMS) global surgical period for determination of the appropriate allowance of the Evaluation and Management (E & M) visits. E & M procedure codes, which are submitted within the established global period for the surgical procedure code, will be denied. The edit error code 1091, procedure code billed within pre-op time frame – ClaimCheck or edit error code 1092, procedure code billed within post-op time frame – ClaimCheck, will be reported on the Remittance Advice.

Procedure Code Billed	Description	Procedure Code Paid	Procedure Code Denied
Example 1			
99233 (Date of Service = 07/13/05)	Subsequent hospital care		99233
33249 (Date of Surgery = 7/14/05)	Insertion of cardioverter-defibrillator	33249	
99233 (Date of Service = 7/15/05)	Subsequent hospital care		99233
Example 2			
99203 (Date of Service = 12/12/04)	Office E&M		99203
59400 (Date of Service = 1/21/05)	Routine Labor & Delivery, with antepartum & postpartum	59400	
99203 (Date of Service = 2/28/05)	Office E&M		99203

Assistant Surgeon Edit: This edit uses information from the American College of Surgeons designations for procedure codes that are allow for the utilization of an Assistant Surgeon. This edit will be used whenever Modifiers 80, 81, or 82 are submitted with the procedure code. Reimbursement will be 20% of the established surgical fee on file. (Edit Error Code 1064, "Procedure Code Does Not Require Assistant Surgeon – ClaimCheck")

Age Conflict Edit: This edit occurs when an age-specific procedure code is submitted for a recipient whose age is outside of the designated age range of the procedure. The age of the recipient will be determined based on the recipient's eligibility file. Claims for this edit will be denied. (Edit Error Code 1065, "Procedure Code Conflicts With Age – ClaimCheck")

Gender Conflict Edit: This edit occurs when a gender-specific procedure code is submitted for a recipient whose sex is outside of the designated gender of the procedure. The sex of the recipient will be determined based on the recipient's eligibility file. Claims for this edit will be denied. (Edit Error Code 1067, "Procedure Code/Sex Code Conflict – ClaimCheck")

Obsolete Procedure Edit: This edit occurs when a procedure code is submitted that is no longer performed under prevailing medical standards. These procedure codes usually are replaced by newer, more effective procedures. Procedure codes that have been determined to be obsolete will be denied. (Edit Error Code 1079, "Procedure Code Not In Use On Date Of Service – ClaimCheck")

Modifier Usage: DMAS will begin recognize specific modifiers to determine the appropriate exclusion of claims from the ClaimCheck process. The following modifiers will be recognized to exclude the claim from the ClaimCheck edits when appropriately used as defined by the most recent Current Procedural Terminology (CPT).

Procedure Code Billed	Description	Procedure Code Paid	Procedure Code Denied
Example 1			
99203 (Date of Service = 9/15/05)	Office E & M		99233
43453 (Date of Service 9/15/05)	Dilation of the esophagus	43453	
99233 (Date of Service = 9/17/05)	Subsequent Hosp. care		99233
Example 2			
99203, mod 25 (Date of Service = 9/15/05)	Office E & M	99233	
43453 (Date of Service = 9/15/05)	Dilation of the esophagus	43453	
99233 (Date of Service = 9/17/05)	Subsequent Hosp. care		99233

ClaimCheck Error Message Reasons

Description	Void Reason	EOB for Denied/Voided Claims	EOB for VAMMIS-Generated Claims
Re-bundle	1061	1400	1420
Incidental	1062	1401	
Mutually Exclusive	1063	1402	
Assistant Surgeon Not Required	1064	1403	
Invalid for Patient's Age	1065	1404	
Invalid for Patient's Age - Replace	1066	1405	1421
Invalid for Patient's Sex	1067	1406	
Invalid for Patient's Sex - Replace	1068	1407	1422
Cosmetic	1069	1408	
Unilateral or Bilateral	1076	1409	1423
Bilateral Proc. Greater than 1 Unit	1077	1410	1424
Experimental	1078	1411	
Obsolete	1079	1412	
Pre-Op Visit	1091	1413	
Post-Op Visit	1092	1414	
Max Units Lifetime	1094	1415	1425
Max Units per Day	1095	1416	1426

Procedure Code	Procedure Code Description
15831	Excision, excessive skin and subcutaneous tissue; abdomen
15832	Excision, excessive skin and subcutaneous tissue; thigh
15833	Excision, excessive skin and subcutaneous tissue; leg
15834	Excision, excessive skin and subcutaneous tissue; hip
15835	Excision, excessive skin and subcutaneous tissue; buttock
15836	Excision, excessive skin and subcutaneous tissue; arm
15837	Excision, excessive skin and subcutaneous tissue; forearm or hand
15838	Excision, excessive skin and subcutaneous tissue; submental fat pad
15839	Excision, excessive skin and subcutaneous tissue; other area
19140	Mastectomy for gynecomastia
19316	Mastopexy
19318	Reducion Mammaplasty
19324	Mammaplasty, augentation, without prosthetic implant
19325	Mammaplasty, augentation, with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal of mammary implant material
19340	Immediate insertion of breast prothesis following mastopexy, mastectomy, or in reconstruction
19357	Breast reconstruction, immediate or delay, with tissue expander, including subsquent expansion
21121	Genioplasty, sliding osteotomy, single piece
21122	Genioplasty, sliding osteotomies, two or more
21123	Genioplasty, sliding, augementation with interpositional bone grafts
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision
30435	Rhinoplasty, secondary; intermediate revision
30450	Rhinoplasty, secondary; major revision
54150	Circumcision, using clamp or other device; newborn
54160	Circumcision, surgical excision other than clamp, device or dorsal slit; newborn
67900	Repair of brow ptosis
67901	Repair of blepharotosis; frontalis muscle technique with suture or other material
67902	Repair of blepharotosis; frontalis muscle technique with fascial sling
67903	Repair of blepharotosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharotosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharotosis; superior rectus technique with fascial sling
67908	Repair of blepharotosis; conjunctivo-tarso-Muller's muscle-levator resection
69300	Otoplasty, protruding ear, with or without size reduction
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Evoked otoacoustic emissions; limited

Procedure Code	Procedure Code Description
92588	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparsion of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies
94640	Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device
97139	Unlisted therapeutic procedure
97535	Self-care/home management training - Waiver Services
97537	Community/work re-integration training - Waiver Services
99000	Handling and/or conveyance of specimen for transfer from the Physician's office to a laboratory
99001	Handling and/or conveyance of specimen for transfer from the patient in other than a Physician's office to a laboratory
99050	Services requested after posted hours in addition to basic services
99052	Services requested between 10:00 p.m. and 8:00 a.m. in addition to basic services
99054	Services requested on Sundays and holidays in addition to basic services
99058	Office services provided on an emergency basis
99070	Supplies and materials (except spectacles) provided by the Physician over and above those usually included with the office visit or other services rendered
99080	Special reports such as insurance forms, more than the information conveyed in the ususal medical communications or standard reporting form
99100	Anesthesia for patient of extreme age, under 1 year and over 70
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesis complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency conditions
99172	determination of visual acuity, ocular alignment, color vision by pseudoisochromic plates, and field of vision
99173	Screening test for visual acuity, quantiative, bilateral
99199	Unlisted special services, procedure, or report
99360	Physician standby service, requiring prolonged Physician attendance, each 30 minutes
99509	Home visit for assistance with ADL or personal care - Waiver Services
B4154	Enteral formulae - category IV
B4155	Enteral formulae - category V
G0238	Therapeutic procedure to improve respiratory function - Waiver Services
G9002	Coordinated care fee - Waiver Services
H0040	Crisis Supervision - Waiver Services
H0046	Support Coordination - Waiver Services
H2000	Comprehensive visit - Waiver Services
H2011	Crisis Stablization - Waiver Services
H2014	In-Home Residential Support - Waiver Services
H2017	Psychosocial Rehab - Waiver Services
H2021	PERS Nursing/LPN - Waiver Services
H2023	Support Employment, Individual - Waiver Services
H2024	Support Employment, Enclave/Work Crew - Waiver Services
H2025	Pre-vocational Services, Regular and High Intensity - Waiver Services
Q0136	Injection, epoetin alpha, (for non ESRD use)
Q4054	Injection, darbepoetin alfa (for ESRD on dialysis)

Procedure Code	Procedure Code Description
Q4055	Injection, epoetin alpha, (for ESRD use)
S5102	Adult Day Health Care Services - Waiver Services
S5109	Consumer training - Waiver Services
S5111	Family Care Giver Training - Waiver Services
S5116	Management Training - Waiver Services
S5126	Consumer-Directed Attendance Care - Waiver Services
S5135	Companion Care - Waiver Services
S5136	Consumer-Directed Companion Services - Waiver Services
S5150	Consumer-Directed Respite - Waiver Services
S5160	PERS Installation - Waiver Services
S5161	PERS Monitoring - Waiver Services
S5165	Environmental Modification - Waiver Services
S5185	PERS & Medication Monitoring - Waiver Services
S9122	Home Health aide or CAN, providing care in the home - Waiver Services
S9125	Respite Care, in the home - Waiver Services
T1002	RN Services - Waiver Services
T1003	LPN/LVN Services - Waiver Services
T1005	Respite Care Services - Waiver Services
T1016	Case Management - Waiver Services
T1017	Case Management - Waiver Services
T1019	Personal Care - Waiver Services
T1028	Reassessement Visit - Waiver Services
T1030	Congregate Respite - RN - Waiver Services
T1031	Congregate Respite - LPN - Waiver Services
T1999	Assistive Technology - Waiver Services